DIVISION OF DEVELOPMENTAL DISABILITIES

ELIGIBILITY CHECKLIST FOR DDD STATE SUPPLEMENTARY PAYMENTS (SSP)

Residential/Family Support Services

DATE

CLIENT NAME	CLIENT ID NUMBER	REGION

DATE OF BIRTH	SOCIAL SECURITY NUMBER	C/RM

SSP ELIGIBILITY CRITERIA

- Must be an eligible client of the Division of Developmental Disabilities, **and**
- Must currently be eligible for or receive SSI cash assistance, or would be eligible for SSI except for the receipt of DAC benefits, **and**
- Must have received SSP in lieu of a state-only paid service between August 2002 and present, **or** received a qualifying service between March 2001 and June 2003, **and**
- Must continue to demonstrate a need for this **state-only funded** service.
- A person may be eligible for SSP for more than one service area.

SSI ELIGIBILITY

	Yes	No
Is this person currently eligible for or receiving SSI cash assistance?	☐	☐
Would the person be eligible for SSI except for the receipt of DAC benefits?	☐	☐

If the answer to both questions is "No", the client is not eligible for SSP.

PROGRAM ELIGIBILITY

	Yes	No
Did this person receive SSP in lieu of one or more of the following programs between August 2002 and present or receive a qualifying service between March 2001 and June 2003?	☐	☐
Is this person currently in need of state-only funded services through one or more of the following services?	☐	☐

Check all that apply:

- ☐ Family Support
- ☐ Residential Services (1099 services only)
  - ☐ Voluntary Placement Program
  - ☐ Adult Family Home
  - ☐ Adult Residential Care (ARC)
  - ☐ DDD Group Home
  - ☐ Supported Living
  - ☐ Alternative Living
  - ☐ Agency Attendant Care
  - ☐ Companion Home
  - ☐ Service Allowance/Client Allowance

If the answer to either of these questions is "No", the client is not eligible for SSP.

This person ☐ is ☐ is not eligible for SSP.

CLIENT NAME:

To be completed by the client's representative.

PAYEE		
As long as I receive SSP funding, I agree to have my SSP money sent to my payee:		
NAME	TELEPHONE NUMBER	RELATIONSHIP TO CLIENT
MAILING ADDRESS	CITY	STATE ZIP CODE

PROVIDER INFORMATION	
SSP eligibility is based on assessed need for services. Changes in your living situation or Residential Support provider may affect your need for services. Please provide us with the name of your Residential Support provider.	
PROVIDER/PROGRAM NAME	TELEPHONE NUMBER

CLIENT AND PAYEE RESPONSIBILITIES

- I agree to notify my DDD Case/Resource Manager or Social Worker if I want to change my provider.
- I agree to notify DDD if there is a change in my eligibility for SSI cash assistance.
- I agree to notify DDD if there is any change in my living situation.
- I agree to notify DDD if there is a change in my Payee. I received SSP Payee information.

PLEASE SIGN AND RETURN THIS PAGE TO DDD

I agree that the information on this form is correct.

SIGNATURE OF CLIENT OR REPRESENTATIVE	DATE
SIGNATURE OF DSHS REPRESENTATIVE	DATE

cc: Client Service Plan